

RONALD FANTOZZI

16 OF 18

St. Mary's Regional Medical Center
Patient Progress Notes

ID Code For Clinical Services:**NS-Nursing Service**

R-Radiology

CS - Cardiology Services

DS-Dietary Service

RC-Respiratory Care

RT-Recreation Therapy

PC-Pastoral Care

ED-Pt. Educator

OT-Occupational Therapy

SW-Social Work

PH-Pharmacy

PT-Physical Therapy

ST-Speech Therapy

7259582

KS

NR

021545

9/16/97 MAILHOT, PAUL

FANTOZZI, RONALD R

40 FCLAND RD

AUBURN

NE 04210

0751

██████████/62 M/M 207-7823079

218103-01

99990089

ID	Key	Date	Time	Notes	Signature
NS	9/21	07-19		<p>Alt. in comfort. (5) C/O in left side of abd</p> <p>(A) Med. to Percocet 11 9+10 Valium 10^{mg} - 1st</p> <p>(P) meds 5 good effect - 9 pain left side of abd - Buprenex 18^{mg} to some relief</p> <p>(P) Cont. w/o medication - encouraged to take pills for pain - Also distended. Tendr to touch left side - voiding in good amt. Nausea Hall Gait Steady - C/O dyspnea while walking in hall. back to bed - in bed - Bil. hips red edematous worse to touch. One swollen than yesterday -</p>	M. Marmen
NS	9/21	19	19	<p>#1 (A) to D flank pain</p> <p>(B) medicated to Percocet but refused stated he preferred Buprenex. Dr. Maibach called. He'd Buprenex & ordered Ultram Ultram 500mg po i given @ 22³⁰ + 2¹⁵</p> <p>(C) States that medication doesn't work as well as the injection.</p> <p>(D) Continue to assess level of pain, medicate as needed, document it.</p> <p>Gen Cx: Voiding 1x with 300cc+ it tea color. Gd feeling like he is not emptying bladder. Abdomen distended, 1 Grim & tenser. Str. with C. 22³⁰ for 550cc it tea colored. and Bil T buttocks area Perium red + edematous</p>	

140070

500685.011.0421

St. Mary's Regional Medical Center Patient Progress Notes

ID Code For Clinical Services:

NE Nursing Service

R-Radiology

CS - Cardiology Services

Notary Service

RC-Respiratory Care

RT-Recreation Therapy

PC National Care

ED-Pt. Educator

OT-Occupational Therapy

SW-Social Work

PH-Pharmacy**PT-Physical Therapy**

ST-Speech Therapy

7259582 MS MR 221542
9/16/97 NAILHOT, PAUL E
FANTOZZI, RONALD M
140 POLAND RD
AUBURN NE 04219
0355 7/62 M/M 207-762387
221103-01 99990089

IN Key	Date	Time	Notes	Signature and Time
N/S	9/20	0700	M1, M2 D: 4/6 (L) side pain diff varying abd. firm	
		1600	o discharged O varies for 12 hrs.	
			A: Str. last c H15 lacheter for 700cc tea-colored	
			urine P. instructed on self-cath technique using	
			clean technique Must c Renout x2 at 930 at 1430	
			R: Pain relief achieved	
			P: Discharged via wife accompanied by wife -	
			complete DIC instructions given	J. J. J.

St. Mary's Regional Medical Center Patient Education Progress Notes

ID Code For Clinical Services:		CS - Cardiology Services		7259582 NS NR 221342 9/16/97 NAILHOT, PAUL R FANTOZZI, RONALD H 40 PCLAND RD AUBURN ME 04210 CTSY 62 H/R 207-7823875 218103-01 99990089
NS-Nursing Service	R-Radiology	RT-Recreation Therapy		
DS-Dietary Service	RC-Respiratory Care	OT-Occupational Therapy		
PC-Pastoral Care	ED-Pt. Educator	PT-Physical Therapy		
SW-Social Work	PH-Pharmacy	ST-Speech Therapy		
Teaching Codes:				
Individual(s) Instructed:		Method:	Understanding:	
P-Patient	W-Written	DU-Demonstrates	Understanding	
F-Family	V-Verbal	N-Needs Further Instruction		
S-Significant Other	AV-Audio/Vis.	RD>Returns Demonstration		
	D-Demonstration			

ID	Date	Time	Topic	Individual(s)	Method	Understanding	Comments	Signature & Title
NS	9/17/97	07:49	peri-op	(P) F S	W (V) AV D	DU N RD		B. Brady
			peri-op	(P) F S	W (V) AV D	DU N RD		
			activity	(P) F S	W (V) AV D	DU N RD		
			diet	(P) F S	W (V) AV D	DU N RD		
			day care	(P) F S	W (V) AV D	DU N RD		
NS	9/18	07:10	Diabetes	(P) F S	W (V) AV D	DU N RD		B. Brady
			Diabetes	(P) F S	W (V) AV D	DU N RD		
			Diabetes	(P) F S	W (V) AV D	DU N RD		
			Diabetes	(P) F S	W (V) AV D	DU N RD		
			Diabetes	(P) F S	W (V) AV D	DU N RD		
			Diabetes	(P) F S	W (V) AV D	DU N RD		
			Diabetes	(P) F S	W (V) AV D	DU N RD		
NS	9/19		Medication plan to	(P) F S	W (V) AV D	DU N RD	Review time-void.	M. Armstrong
			Diabetes plan to	(P) F S	W V AV D	DU N RD	pt p f f f f f f f f	
NS	9/20		Medication	(P) F S	W (V) AV D	DU N RD	Reviewed to PT	
			Diabetes	(P) F S	W V AV D	DU N RD	the time void	
				(P) F S	W V AV D	DU N RD	the time void	
	9/21		Plan medication	(P) F S	W (V) AV D	DU N RD	Review to PT	
				(P) F S	W V AV D	DU N RD	the importance	
				(P) F S	W V AV D	DU N RD	of taking pt. with	
NS	9/22	10:00	Diabetes	(P) F S	W (V) AV D	DU N RD	Self-care instructions	
				(P) F S	W V AV D	DU N RD	admission reviewed	
NS	9/22	10:00	Diabetes	(P) F S	W (V) AV D	DU N RD	Complete O/C	
				(P) F S	W V AV D	DU N RD	Instructions given	
				(P) F S	W V AV D	DU N RD		
				(P) F S	W V AV D	DU N RD		
				(P) F S	W V AV D	DU N RD		
				(P) F S	W V AV D	DU N RD		
				(P) F S	W V AV D	DU N RD		

140071

INSTRUCTION

[illegible]

St. Mary's REGIONAL MEDICAL CENTER					
EMERGENCY DEPARTMENT REPORT					
ADMIT NO 7046597	FC C U	HOW ARRIVED	MED REC NO 00221342	PATIENT NAME FANTOZZI, RONALD M	SERVICE EME
PATIENT ADDRESS 40 POLAND RD		AGE 34Y	DATE OF BIRTH 2/62	PLACE OF BIRTH CT	SEX MAR STATUS M M
CITY, STATE, ZIP AUBURN ME04210	MAIDEN NAME		MOTHER/FATHER NAME		
ATTENDING PHYSICIAN HENSON, JOHN R	NEXT OF KIN/POUSE DEBORAH		NAME AT LAST ADMIT	VETERAN	
PRIVATE PHYSICIAN UNABLE TO OBTAIN	RACE ORIGIN	RELIGION	REV DISCH DATE	EMS NO.	
DATE AND TIME OF SERVICE 2/15/97 19:44	ACCIDENT DATE/HOUR 2/15/97 19:00		DATE AND TIME OF DEATH		
INSURANCE CO NAME HEALTHSOURCE	400 86	POLICY NO. 218103#01	GROUP NUMBER 999999	SUBSCRIBER'S NAME(S) FANTOZZI, RONALD M	
PT PHONE # 207 782-3873				NEXT OF KIN PHONE # 207 782-3873	
PRESENTING COMPLAINT DIZZY/SHAKY/TIGHTNESS				SOC. SEC. # 006542724	
DIAGNOSIS Presyncope					
ALLERGIES		LAST TETANUS			
HISTORY No feeling dizzy all day. Shaky, + SOB upon arrival to home United States pt was hyperventilating Lungs clear Intermittent pain in RUP Red raised rash on both hands occurs +/- short lasting 2-3 quarters. Presyncope. closes eyes. Diarrhea. Pepidyl 100mg Monitor sinus rhythm. 12/80 88 130/80 1120 2005 2005 ps of 03 given on -		VITALS 1950 375 76 28 134/82		PPD 1950 375 76 28 134/82	
PHYSICIAN SIGNATURE [Signature]		MEDICATIONS fin H chron's bronchitis Hepatitis B thyroid eye pills Balm 2 cups juice Tylenol 650mg @ 2115		LABORATORY CBC LYTES BUN ES AMYLASE ETOH PCW SPEC COAG TIA 24 50 RED WBC HOLD HGB 12 HCT 35 HPL 44 PLT 250 WBC 10.0 DIFF 40% NEUT 50% LYM 10% MON 0% EOS 0% BAS 0%	
MEDICAL RECORDS					

500685.011.0426

☐ PATIENT CALLED WITH LABORATORY / X-RAY RESULTS: _____ DATE _____ TIME _____ INITIALS _____

**St. Mary's Regional Medical Center
Consent/Assignment/Authorization Statement**

Consent for Treatment

Admission Date: _____

I, the undersigned a patient in this St. Mary's Regional Medical Center ("SMRMC"), hereby authorize employees of SMRMC and physicians(s) (and whomever they may designate as assistants) to administer such treatment as is necessary, and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also consent to the administration of such anesthetics as are necessary. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with accustomed practice. I hereby certify that I have read and fully understand the above Consent for Treatment, the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which may have been explained to me by the attending physician. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization To Release Medical Information

St. Mary's Regional Medical Center is hereby authorized and requested to furnish the HealthSource insurance company(s) or its properly authorized agent, my employer and any peer review organization which conducts reviews of hospital utilization under an agreement with my employer and/or health insurance carrier, or any person or corporation that is or may be liable, under contract or otherwise, for all or part of the Medical Center's charge; all information required by it to determine benefits, including nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to said hospital.

Assignment Of Benefits

I hereby assign unto St. Mary's Regional Medical Center and related contracted professionals, all hospital insurance benefits now due and to become due and payable to me or on my behalf, but not to exceed the Medical Center's charges by virtue of my treatment by the hospital, and I hereby direct the HealthSource Insurance Company(s) to pay such benefits directly to the hospital in consideration of the hospital care and services furnished and to be furnished by the hospital.

Payment Terms

I understand payment of charges is due for services rendered within 30 days including any collection or attorney fees. If I am financially unable to do so I agree to complete a detailed financial statement so alternative payment arrangements can be determined.

Release From Responsibility For Personal Property

I understand and agree that under no circumstances will St. Mary's Regional medical Center be responsible for personal property. I take full responsibility for retaining in my possession or custody any and all such articles.

Authorization For Payment Of Medical Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other medical insurers, any information needed for this or a related Medicare, or other medical insurance claim. I request that payment of authorization of authorized benefits be made to St. Mary's Regional Medical Center and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services I request this authorization apply to the extent of my services.

An Important Message From Medicare/Champus

I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

I Have Read This Consent/Authorization Completely And Crossed Out Any Words Or Phrases That I Do Not Accept:

Patient Signature: _____

Date: FEB 15 2003

Time: _____

Guarantor Signature _____

Date: _____

Relationship _____

Witness Signature _____

Date: FEB 15 2003

Telephone Consent Received By: _____

Date: _____

Time: _____

500685.011.0427



EMERGENCY DEPARTMENT - 777-8120
AFTERCARE INSTRUCTIONS

11/16/02 MR 221342
F. J. P. DONALD H
221342 01 999999

Emergency Department Treatment is only the first step in your care. Follow up care may be important for your health and safety.

If you get worse, get new symptoms or don't get better, call your physician or return to the Emergency Department any time day or night.

X-rays and cardiograms (EKGs) are initially read by the Emergency Physician. They will also be reviewed by the hospital radiologist or cardiologist. You will be notified if any significant additional findings are noted.

You will be sent a separate bill for Emergency Physician care in the hospital Emergency Department. If you have any questions about the Emergency Physician's bill, please do not hesitate to contact us, toll free 1-800-403-6726.

PLEASE FOLLOW THE INSTRUCTIONS CHECKED BELOW:

- () Take your medication as ordered.
() Follow instruction sheet.
(x) See Dr. Boulanger for follow up on 1-2 week at 1 days.
() Call Dr. Boulanger tomorrow, for appointment in 1 days.
() May return to school on 1 / 1 / 1.
() May return to Gym on 1 / 1 / 1.
Limitations _____
() May return to REGULAR/LIMITED DUTY work on 1 / 1 / 1.
() Work as bandage/splint allows () No lifting
() One hand/one arm work () No lifting over _____ lbs.
() Dry work only () No squatting/kneeling
() Other () No bending or twisting
() Call WORK MED for appointment on 1 / 1 / 1 at 777-8816

OTHER

- Drink plenty of fluids
- Please see
Continue by Dr. Boulanger
Breathing

I HAVE READ AND UNDERSTAND THE ABOVE INSTRUCTIONS:

Date Time ED Nurse Physician's Name Patient Signature

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

500685.011.0428

FANTOZZI, Ronald M. Henson SMRMC 02/15/97
 MR#: 221342 ACCT#: DOB: [REDACTED]/62 IN: 1944 EXAM: 2030

PROBLEM: Shakiness.

HPI: The patient is a 34-year-old male with a history of anxiety disorder as well as hepatitis C and Crohn's disease. He has had over a two year history of intermittent episodes of feeling dizzy. He describes this as feeling like he is going to pass out. He denies any vertigo. Symptoms will occur when he looks from far away to near vision. He also has it when he stands up or when he closes his eyes. It has been happening more recently. He has also had hyperventilation, anxiety, which occurs after his dizziness. Hyperventilating and noticing tingling and carpal-pedal spasm, using a paper bag without much relief. The patient denies any chest pain or headache.

ALLERGY:

MEDS:

IMM:

PMD:

EXAM: General appearance: The patient is a white male who appears anxious and tired. Vital signs .

SKIN: Warm and dry.

HEENT: TMs normal. Fundi benign.

LUNGS: Breath sounds equal and completely clear to auscultation with no rales or wheezes.

HEART: Normal S1, S2 with no murmurs, rubs or gallops.

NEUROLOGIC: Mental status: Alert and oriented times three. Cranial nerves: Pupils equal, round and reactive to light. Extraocular movements are intact. The remainder of the cranial nerves are grossly intact. Strength 5/5 in all four extremities. Sensation intact to light touch throughout. Gait is normal. Deep tendon reflexes are 1-2+ and symmetric throughout.

COURSE/PROCEDURES: **EKG:** The electrocardiogram which was read by the emergency physician shows normal sinus rhythm. Normal axis, normal intervals. No significant ST or T wave abnormalities.

The patient was reassured that at this time there is an extremely low risk of any damage or harm to himself with these episodes, however, he was urged to follow-up with Dr. Belanger to be re-evaluated. He was noted to be orthostatic. When going from lying to sitting his pulse rose from 88 to 120 with a fairly stable blood pressure.

He is encouraged to drink plenty of fluids. The patient was given 16 ounces of orange juice in the department. He will call if any increased problems.

DX:

Pre-syncope/anxiety disorder with symptoms of carpopedal spasm and hyperventilation. U

Dictate, Inc. 207-539-8477 for NES-St. Mary's Regional Medical Center

ORIG. COPY

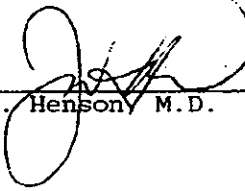
Page 1 of 2

500685.011.0429

FANTOZZI, Ronald M. Henson SMRMC 02/15/97
MR#: 221342 ACCT#: DOB: [REDACTED] /62 IN: 1944 EXAM: 2030

MDM/TX/COUNSEL/COORD:

1. As above.



John R. Henson M.D.

DOD:02/15/97 JRH/dml

DOT:02/15/97

cc: Dr. Belanger

Dictate, Inc. 207-539-8477 for NBS-St. Mary's Regional Medical Center

02/15/97

Page 2 of 2

500685.011.0430

ST. Mary's Regional Medical Center
Dept. EM

02/15/1997 20:51:46
34 years Male

Operator: 5022

ECG MACHINE INTERPRETATION
RiteCare
Physician Interpretation

Rate: 77
PR: 157
QRS: 91
QT: 336
QTc: 350

AXES:
P: 5
QRS: 44
T: 53

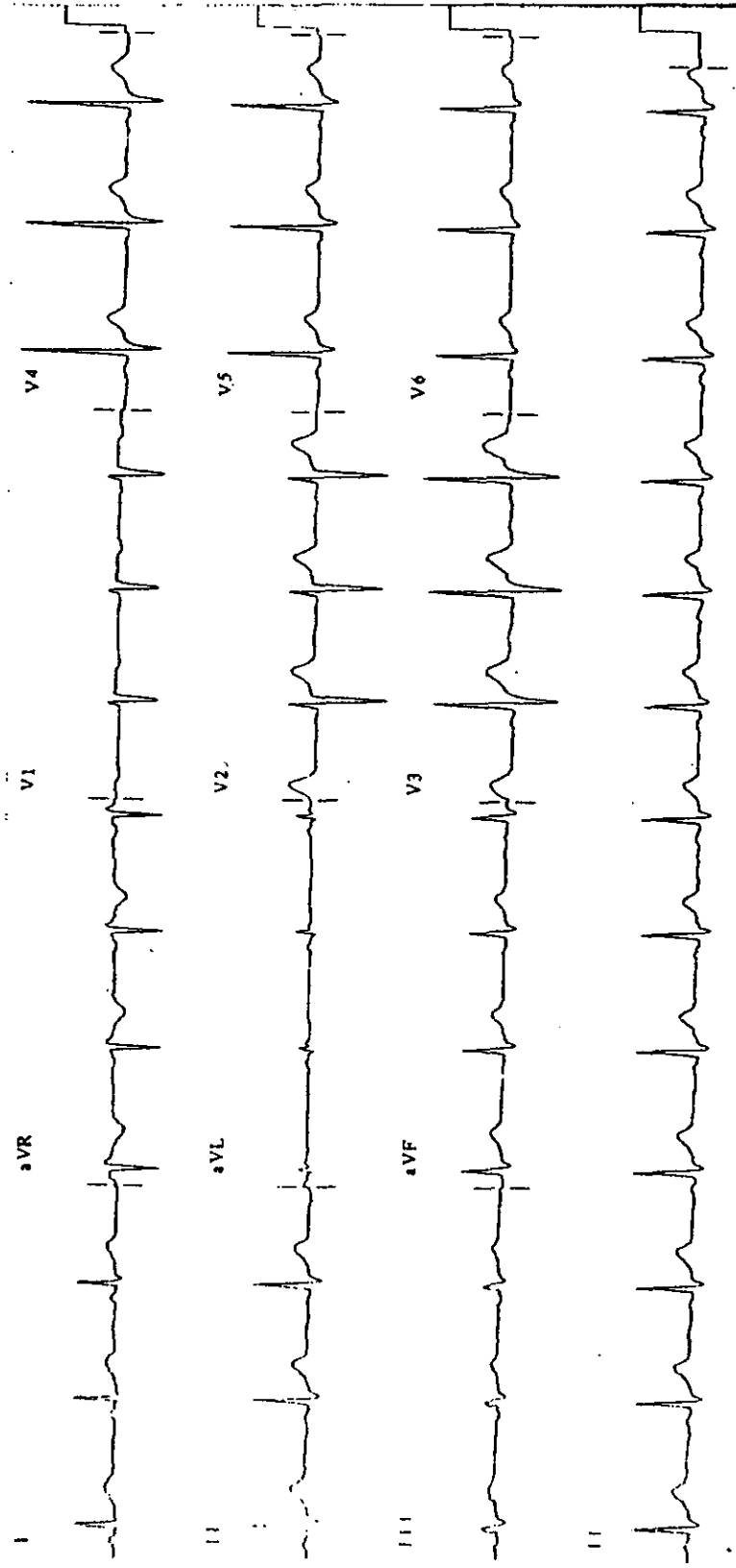
TRANS: 35 2/16/97

SINUS RHYTHM.
NORMAL.

- OTHERWISE NORMAL ECG -
D. ABISALIH, M.D.

DOR: [redacted] /62
DX: HYPERVENTILATION/SCE
Requested by: HENSON

PRELIMINARY-MD MUST REVIEW



LOC 0000-4420 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV

F 60% 0.5-40 Hz W

H708 08906

RUN REPORT #		Mo	Day	Year	M	F	SUN	SERVICE NAME	SERVICE NO.	VEHICLE NO.	ALS	SERVICE RUN #
440743		2	15	97				United Ambulance	72	1	<input type="checkbox"/> Performed <input type="checkbox"/> Back-Up <input type="checkbox"/> Called	1403
NAME 2nd Lt. Fox, 2231								Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Insured <input type="checkbox"/> Other <input type="checkbox"/> Self-Pay <input type="checkbox"/> None <input type="checkbox"/> Unknown				
STREET OR R.F.D. 46 Polk Rd								MR # 221342				
CITY - TOWN Holtville				STATE Mo.		ZIP 64216		218103 01				
AGE / DATE OF BIRTH 34 / 4-16-62		<input type="checkbox"/> Male <input type="checkbox"/> Female		PHONE 782 3873								
INCIDENT LOCATION: Scene		SITE CODE 00		CITY / TOWN								
TRANSPORTED TO: Sm Rmc.		TREATING / FAMILY PHYSICIAN Boulanger		CREW LICENSE NUMBERS 1014								
TRANSPORTATION / COMMUNICATIONS PROBLEMS 11830												

<input type="checkbox"/> Medical <input type="checkbox"/> Cardiac <input type="checkbox"/> Poisoning/OC <input type="checkbox"/> Respiratory <input checked="" type="checkbox"/> Behavioral <input type="checkbox"/> Diabetic <input type="checkbox"/> Seizure <input type="checkbox"/> CVA <input type="checkbox"/> OB/GYN <input type="checkbox"/> Other <input type="checkbox"/> Cardiac Arrest/Code 99		<input type="checkbox"/> Trauma <input type="checkbox"/> Multi-Systems Trauma <input type="checkbox"/> Head <input type="checkbox"/> Spinal <input type="checkbox"/> Burn <input type="checkbox"/> Soft Tissue Injury <input type="checkbox"/> Fractures <input type="checkbox"/> Other		<input type="checkbox"/> AOB / ETOH <input type="checkbox"/> MVA <input type="checkbox"/> Auto/Truck <input type="checkbox"/> Motorcycle <input type="checkbox"/> Snowmobile <input type="checkbox"/> ATV <input type="checkbox"/> Pedestrian <input type="checkbox"/> Helmet <input type="checkbox"/> Childseat <input type="checkbox"/> Airbag		<input checked="" type="checkbox"/> R <input type="checkbox"/> L Lung Sounds <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Absent <input type="checkbox"/> Decreased <input type="checkbox"/> Rales <input type="checkbox"/> Wheeze <input type="checkbox"/> Stridor		TIME 1906	CODE 3	ODOMETER Call Received
<input type="checkbox"/> CHIEF COMPLAINT: Dizzy spell		<input type="checkbox"/> MEDICATIONS 0		<input type="checkbox"/> ALLERGIES NKA		TYPE OF RUN <input checked="" type="checkbox"/> Emergency <input type="checkbox"/> Transport <input type="checkbox"/> Routine <input type="checkbox"/> Transfer <input type="checkbox"/> Emergency <input type="checkbox"/> Transfer <input type="checkbox"/> No Transport <input type="checkbox"/> Refused Transport		TIME 16	CODE 1	ODOMETER AI Scene
								TIME 30	CODE 1	ODOMETER From Scene
								TIME 40	CODE 1	ODOMETER AI
								TIME 49	CODE 1	ODOMETER In Service

TIME	PULSE	RESP	BP	PUPILLARY RESPONSE	SKIN	EYE OPENING RESPONSE	VERBAL RESPONSE	MOTOR RESPONSE	CAPILLARY REFILL
	98	24	130/82		u/p	3 2 1	4 3 2 1	6 5 4 3 2 1	<input type="checkbox"/> Normal <input type="checkbox"/> Delayed <input type="checkbox"/> None
						4 3 2 1	5 4 3 2 1	6 5 4 3 2 1	<input type="checkbox"/> Normal <input type="checkbox"/> Delayed <input type="checkbox"/> None
						4 3 2 1	5 4 3 2 1	6 5 4 3 2 1	<input type="checkbox"/> Normal <input type="checkbox"/> Delayed <input type="checkbox"/> None

8. pt. Sheld L has 4x seizure attacks # crises, 4x Hypertensive
? Hypertensive B.

C 34 yo ♂ C Act 3 hpy on Seta monitor sinus - sinus tach.
pulse of 98 24 24 02

7. 4x Seizure monitor, pulse of 0, moved off 6 unit, received transported
called Housc e report, transfered; P.E. EE staff

MUTUAL AID Assisted/Assisted by Service # PATIENT'S SUSPECTED PROBLEM		Time Called 440743	<input type="checkbox"/> Medication Administered <input type="checkbox"/> Monitor <input type="checkbox"/> Patient	<input type="checkbox"/> Dribb <input type="checkbox"/> Lic # <input type="checkbox"/> Chest Comp <input type="checkbox"/> Craniotomy	<input type="checkbox"/> C-Vert <input type="checkbox"/> Written Order/Protocol <input type="checkbox"/> Verbal Order/Protocol
Suspected Artery Artificial Respiration/BVM Oxygenation/Artery Nasopharyngeal Airway Endotracheal Tube Rebreather AED Suction Oxygenator A-Scope		Extubation Manual Immobilization Cervical Board Long Board Restraints Traction Splinting Cervical Splinting Cold Application MAST Initiated Assess with Masts Rapid Assessment/Rescue Unit	MEDICAL CONTROL IV SUC LIC # UNSUC LIC # ET SUC LIC # UNSUC LIC #		
Total Attempt Total Attempt		MEDS DEFER C-VERT MED # POS WS ROUTE			

COPY 1 HOSPITAL

500685.011.0432

Competent Patient

1. ☐ EMS feels transportation is indicated. This is to certify that I, _____ am:

☐ Refusing treatment.

☐ Refusing transier offered by the EMS service and its representatives. I acknowledge that I have been informed of the risk involved and hereby release the licensed emergency medical persons, the Regional Medical Director and his designees for all responsibility for my ill effects which may result from this action.

Witness: _____ Signed: _____

Patient name/relative

2. ☐ The patient refuses EMS evaluation and transport. EMS feels that transport is not indicated.
3. ☐ The patient is evaluated by EMS and then refuses transport. EMS feels that transport is not warranted.
4. ☐ The patient requests transport. EMS evaluates the patient and feels transport is not indicated. On-Line Medical Control Contacted: _____

Name OLMC

OLMC Order

☐ Transport

☐ No Transport. The patient is advised to seek medical care through alternate means of transportation.

Incompetent Patient

☐ On-line Medical Control requests transport.

☐ On-line Medical Control agrees medical transport not needed.

☐ The patient or nearest relative is advised to seek medical care through alternate means of transportation.

8A70AA

St. Mary's
REGIONAL MEDICAL CENTER

2966

EMERGENCY DEPARTMENT REPORT				ST. Mary's REGIONAL MEDICAL CENTER				2966	
PATIENT NO. 6134001		CITY STATE ZIP 93 PIERCE ST LEWISTON		PATIENT NAME FANTOZZI, RONALD M		SERVICE EME		DATE 5/13/96	
AGE 34Y		DATE OF BIRTH 5/62		PLACE OF BIRTH CT		SEX M		STATUS M	
MOTHER FATHER NAME		MOTHER FATHER NAME		MOTHER FATHER NAME		MOTHER FATHER NAME		MOTHER FATHER NAME	
ATTENDING PHYSICIAN OWENS, WILLIAM		NEXT OF KIN SPONSOR /DEBORAH RADEBORAH RAN		NAME AT LAST ADMIT 823873/		VETERAN		CONDITION AT DISCHARGE	
BIOLOGICAL PHYSICIAN BOULANGER, MICHAEL J		RACE ORIGIN C		RELIGION 81		PREV DISCH DATE		EMS NO	
DATE AND TIME OF SERVICE 5/13/96 4:09		ACCIDENT DATE/HOUR 5/13/96 3:30		DATE AND TIME OF DEATH		TREATED & REFERRED TO		LR	
INSURANCE CO NAME HEALTHSOURCE		POLICY NO 218103#01		GROUP NUMBER 999999		SUBSCRIBER'S NAME(S) FANTOZZI, RONALD M			
PT PHONE # 707 782-3873		NEXT OF KIN PHONE #		SOC SEC #		006542724			
PRESENTING COMPLAINT ACUTE LEFT SIDED ABDOMINAL PAIN									
DIAGNOSIS Hemorrhage - Probable Renal Left Nephros									
A. ERGIES 4/4/85 / 4/4/85 / 4/4/85									
TRAUMA 0200 acute onset LLQ abd pain described as constant, stabbing, nonradiating. Hx Cochran's. Reports of recent illness fever, or travel. P. vomiting in ED described difficulty urinating. Dennis flank pain. 4/4/85									
MEDICATIONS 25-50 NR Den-50 Phm 25/100									
EX PROCEEDING 6700 Renal SS in IV in X-ray 4/4/85 Den-50 Phm 25/100									
DISCHARGE INFORMATION Discharged amb. Meds received 5/13/96 1100									

500685.011.0434

PATIENT CALLED WITH LABORATORY / X-RAY RESULTS: _____
 DATE _____ TIME _____ INITIALS _____

CONSENT FOR TREATMENT

I hereby authorize the Physician or Physicians (and whomever he or they may designate as his or their assistants) in charge of my care at ST. MARY'S, to administer any emergency treatment and to administer such anesthetics and perform such operations and procedures as he or they may deem necessary or advisable in the diagnosis and treatment of my condition, recognize that the need for prompt medical attention precludes authorization of a more detailed or specific nature before proceeding, and to send the complete medical record to my Physician or the Physician I am referred to.

WITNESS _____ SIGNATURE _____ DATE AND TIME _____

Because the above patient is an unemancipated minor, _____ years of age, or, is unable to sign for the following reasons:

The above consent is given on the patient's behalf by:

WITNESS _____ CLOSEST RELATIVE OR LEGAL GUARDIAN _____

DATE _____ TIME _____ RELATIONSHIP _____

(NOTE, IF TELEPHONE CONSENT) _____

SAINT MARY'S REGIONAL MEDICAL CENTER

Lewiston, Maine

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

This is to certify that I, _____, an out-patient at St. Mary's Regional Medical Center, am leaving against the advice of the attending Physician and Medical Center authorities. I also acknowledge that I have been informed of the risk involved and hereby release the attending Physician and Medical Center from all responsibility for any ill effects which may result.

WITNESS _____ SIGNATURE OF PATIENT OR PARENT, IF MINOR _____

DATE _____ TIME _____

I _____ give St. Mary's Regional Medical Center Emergency Department staff permission to photograph my injuries. I understand that these photographs will remain in the Medical Center and be available if needed for legal purposes in the future.

Although duplicate copies will be taken, an original must always remain in the hands of the Medical Center.

WITNESS _____ SIGNATURE OF PATIENT OR PARENT, IF MINOR _____

St. Mary's Regional Medical Center **Consent/Assignment/Authorization Statement**

Consent for Treatment

Admission Date: _____

I am undersigned a patient in this St. Mary's Regional Medical Center ("SMRMC"), hereby authorize employees of SMRMC and its assistants (and whomever they may designate as assistants) to administer such treatment as is necessary, and such additional procedures or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also consent to the administration of such anesthetics as are necessary. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with accustomed practice. I hereby certify that I have read and fully understand the above Consent for Treatment, the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which may have been explained to me by the attending physician. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization To Release Medical Information

St. Mary's Regional Medical Center is hereby authorized and requested to furnish the Healthsource insurance company(s) or its properly authorized agent, my employer and any peer review organization which conducts reviews of hospital utilization under an agreement with my employer and/or health insurance carrier, or any person or corporation that is or may be liable, under contract or otherwise, for all or part of the Medical Center's charge; all information required by it to determine benefits, including nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to said hospital.

Assignment Of Benefits

I hereby assign unto St. Mary's Regional Medical Center and related contracted professionals, all hospital insurance benefits now due and to become due and payable to me or on my behalf, but not to exceed the Medical Center's charges by virtue of my treatment by the hospital, and I hereby direct the Healthsource Insurance Company(s) to pay such benefits directly to the hospital in consideration of the hospital care and services furnished and to be furnished by the hospital.

Payment Terms

I understand payment of charges is due for services rendered within 30 days including any collection or attorney fees. If I am financially unable to do so I agree to complete a detailed financial statement so alternative payment arrangements can be determined.

Release From Responsibility For Personal Property

I understand and agree that under no circumstances will St. Mary's Regional medical Center be responsible for personal property. I take full responsibility for retaining in my possession or custody any and all such articles.

Authorization For Payment Of Medical Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other medical insurers, any information needed for this or a related Medicare, or other medical insurance claim. I request that payment of authorization of authorized benefits be made to St. Mary's Regional Medical Center and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services I request this authorization apply to the extent of my services.

An Important Message From Medicare/Champus

I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

I Have Read This Consent/Authorization Completely And Crossed Out Any Words Or Phrases That I Do Not Accept:

Patient Signature: _____

Date: 5-13-96

Time: 0415

Physician Signature: _____

Date: 5-13-96

Relationship: _____

Witness Signature: _____

Date: _____

Telephone Consent Received By: _____

Date: _____

Time: _____

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500685.011.0436



EMERGENCY DEPARTMENT - 777-8120
AFTERCARE INSTRUCTIONS

2/16/92 KP 221342
 RONALD H
 E ST
 NE 24240
 999999

7823873

Emergency Department Treatment is only the first step in your care. Follow up care may be important for your health and safety.

If you get worse, get new symptoms or don't get better, call your physician or return to the Emergency Department any time day or night.

X-rays and cardiograms (EKGs) are initially read by the Emergency Physician. They will also be reviewed by the hospital radiologist or cardiologist. You will be notified if any significant additional findings are noted.

You will be sent a separate bill for Emergency Physician care in the hospital Emergency Department. If you have any questions about the Emergency Physician's bill, please do not hesitate to contact us, toll free 1-800-403-6726.

PLEASE FOLLOW THE INSTRUCTIONS CHECKED BELOW:

- () Take your medication as ordered.
 () Follow instruction sheet _____
 () See Dr. _____ for follow up on _____ / _____ / _____ at _____
 () Call Dr. _____ tomorrow, for appointment in _____ days.
 () May return to school on _____ / _____ / _____
 () May return to Gym on _____ / _____ / _____
 Limitations _____
 () May return to REGULAR/LIMITED DUTY work on _____ / _____ / _____
 () Work as bandage/splint allows () No lifting
 () One hand/one arm work () No lifting over _____ lbs.
 () Dry work only () No squatting kneeling
 () Other () No bending or twisting
 () Call WORK MED for appointment on _____ / _____ / _____ at
 777-8816

OTHER _____

① Follow up with Dr. Maihot
 on May 30th @ 3:00 PM.

② Call office in AM 5/30/96

③ Call primary care physician for
 referral

④ Take med as directed
 ⑤ Return with any problems

I HAVE READ AND UNDERSTAND THE ABOVE INSTRUCTIONS

5/13/96

1055

ED Nurse

Physician's Name

Patient Signature

ACCOUNT NUMBER 623 4001

~~S~~ANTOZZI, Ronald Gage SMRMC 05/13/96
MR# 221342 ACCT #

ADDENDUM

The patient was in in X-ray at the time of transfer.

X-RAYS: Read by the _____
IVP: Showed no obstructive lesions possible calculi in the left kidney.
There was mild dilatation of the left ureter significant possible passed stone.

After return from X-ray he was basically reporting that his pain was continuing to be an 8/10, although he was able to sleep fairly soundly, although awakened easily. He received 30 mg of Toradol IV. This seemed to relieve his pain significantly.

Dr. Mailhot had been consulted prior to my arrival and passed through the Emergency Department, reviewed the films and felt that it would be all right for the patient to be discharged home.

DX:

1. Hematuria, possible passed calculi.

PLAN:

1. He is given a prescription for Tylox - dispensed #10 - 1 to 2 po q4-6h prn pain.
2. Return for severe pain.
3. Otherwise follow-up with Dr. Mailhot as scheduled in about 2 weeks for further evaluation of his hematuria.

Note - Because he had narcotics he was told that he could not drive. He made a phone call and then was observed to get into his own vehicle and drive off in spite of his instructions not to.

CONDITION AT DISCHARGE: Good, ambulatory.

Time Out: 1150

John Gage, MD

DOD:05/13/96 JG /rlw

DOT:05/13/96

cc: Dr. Mailhot
Dr. Boulanger

Dictate, Inc. 207-539-8477 for NES-St. Mary's Regional Medical Center

ORIG. COPY

Page 1 of 1

500685.011.0438

ST. MARY'S REGIONAL
MEDICAL CENTER

Lewiston, ME 04240

RADIOLOGY REPORT

Name: FANTOZZI, RONALD M
Pt. Phone: 782-3873
DOB: 62
PHY(S): WILLIAM OWENS, M.D.
PHY(S): MICHAEL BOULANGER, M.D.
Hosp #: 6134001
MR #: 22-13-42
X-RAY #: 08-95-89
Service Date: 05/13/96
NS/Room: ER

OBSTRUCTIVE SERIES 74022

Indication for Study: Acute left flank pain.

FINDINGS:

ABDOMEN: Flat and upright radiographs of the abdomen were obtained. I see no abnormal calcifications in the course of the ureters. A calcification is projected over the left kidney appearing to be within a calyx. No evidence of free air or other abnormality is seen in the alimentary tract. Air contents unremarkable.

CHEST PA chest is normal.

Incidentally noted is a clip in the right upper quadrant consistent with a gallbladder clip.

CONC: Left nephrolithiasis.

No calcifications identified in the course of the ureter above.

IVP 74415

FINDINGS: Again seen is the evidence of a left nephrolithiasis. There is possibly a calcification also in the lower pole calyx on the left. Following the intravenous injection of contrast media, there is prompt opacification of both renal outlines with an excellent nephrotomogram. There is prompt filling of the right pelvicaliceal structures. There is a lucency but I believe this is a crossing defect across the right renal pelvis. The right ureter is normal.

On the left side, the calices fill promptly. The intensity of filling at first is not quite as great on the right, as on the left side the renal pelvis is fuller as is the ureter. At 10 minutes, the entire left ureter is seen but on the upright post void, excellent drainage has occurred. This would suggest that the patient may have recently passed a calculus and have an element of edema but certainly there is no

Continued on next page.

RADIOLOGY REPORT

Page 2

FANTOZZI, RONALD M

Hospital #: 6134001

Date of Service: 05/13/96

MR #: 22-13-42

evidence of obstruction of the ureter. There is a small residual in the bladder following voiding. Again this may be secondary to an element of spasm or hesitancy on the part of the patient but I cannot entirely exclude an element of retained urine. Also noted on these overhead radiographs are multiple staples in the right upper quadrant.

CONC: Left nephrolithiasis.

No calculus seen within the ureter but possible evidence of recently passed calculus.

Incomplete emptying of bladder at time of voiding.

Status post cholecystectomy.

Status post surgery bowel right side with history of Crohn's disease.



JON PITMAN, M.D./rlj

D: 05/13/96 T: 05/13/96

cc:

WILLIAM OWENS, M.D.
X-RAY BACK OFFICE
X-RAY FRONT OFFICE
MICHAEL BOULANGER, M.D.
PHYSICIAN BILLING
RAD

(N)
(Q)
(Q)
(F)
(Q)
(Q)

500685.011.0440

ST MARYS REGIONAL MEDICAL CENTER LEWISTON, MAINE 04240 (207)777-8400
 DAVID GALLICK, M.D., DIRECTOR, DEPARTMENT OF PATHOLOGY

PATIENT NAME: FANTOZZI, RONALD M
 DOCTOR: OWENS, WILLIAM
 DOB DATE: A 13-MAY-96
 LOC: ED SEX: M
 SPECIMEN ID: 11601

ACCOUNT #: 6134001
 DATE/TIME COLL: 13-MAY-96 05:02 AM
 DATE RECEIVED: 13-MAY-96
 DATE/TIME REP: 16-MAY-96 08:30 AM

TEST NAME	RESULT	ABNORMAL	REFERENCE RANGE
-----------	--------	----------	-----------------

PLEASE NOTE

*DRAW&HOLD-CHEM SPECIMEN DISCARDED

HEMATOLOGY/COAGULATION

WBC	9.0		4.5-11.0 X10 ³
RBC		4.60 L	4.7-6.1 X10 ⁶
HGB	14.5		14-18 G/DL
HCT		41.9 L	42-52 %
MCV	91.0		80-94 FL
MCH		31.6 H	27-31 PG
MCHC	34.7		33-37 G/DL
RDW	11.6		11.5-14.5 %
PLATELET COUNT	303		130-400 X10 ³
MPV	7.7		7.4-10.4 FL
LYMPHS (COULTER)	31.2		20-35 %
MONO (COULTER)	13.2		0-15 %
GRAN (COULTER)		50.9 L	55-81 %
EOS (COULTER)		4.2 H	0-3 %
BAZO (COULTER)	0.5		0-1 %
SED RATE	19		0-20 MM/HR

CHEMISTRY/CARDIAC/LIPIDS

CALCIUM	10.0		8.7-10.7 MG/DL
PHOSPHORUS	3.5		2.4-4.6 MG/DL
GLUCOSE	103		70-105 MG/DL
BUN	10		7-22 MG/DL
CREATININE	1.0		0.6-1.2 MG/DL
URIC ACID	4.5		3.9-7.8 MG/DL
CHOLESTEROL	149		0-199 MG/DL
TOTAL PROTEIN	7.1		6.0-8.0 G/DL
ALBUMIN	4.3		3.5-4.8 G/DL
GLOBULIN	2.8		2.3-5.3 G/DL
A/G RATIO	1.5		1.1-1.8
TOTAL BILIRUBIN	0.8		0.3-1.2 MG/DL
ALKALINE PHOS	78		37-107 U/L
LD TOTAL	122		94-172 U/L
SGOT	38		8-42 U/L

CHEMISTRY/CARDIAC/LIPIDS (continued on next page)

OWENS, WILLIAM

*** FANTOZZI, RONALD M, 16-MAY-96 AT 08130 ***

FINAL REPORT

500685.011.0441

ST MARYS REGIONAL MEDICAL CENTER LEWISTON, MAINE 04240 (207) 775-8400
 DAVID GALLICK, M.D., DIRECTOR, DEPARTMENT OF PATHOLOGY

PATIENT NAME: FANTOZZI, RONALD M
 DOCTOR: OWENS, WILLIAM
 D/A DATE: A 13-MAY-96
 LOC: ED SEX: M
 SPECIMEN ID: 11601

ACCOUNT #: 6134001
 DATE/TIME COLL: 13-MAY-96 05:02 AM
 DATE RECEIVED: 13-MAY-96
 DATE/TIME REP: 16-MAY-96 08:30 AM

TEST NAME =====	RESULT =====	ABNORMAL =====	REFERENCE RANGE =====
CHEMISTRY/CARDIAC/LIPIDS (continued)			
AMYLASE	50		34-122 U/L

OWENS, WILLIAM

FANTOZZI, RONALD M 13-MAY-96 AT 05:02 AM

FINAL REPORT

ST MARYS REGIONAL MEDICAL CENTER LEWISTON, MAINE 04240 (207)777-8400
DAVID GALLICK, M.D., DIRECTOR, DEPARTMENT OF PATHOLOGY

PATIENT NAME: FANTOZZI, RONALD M
DOCTOR: OWENS, WILLIAM
D/A DATE: 15-MAY-96
LOC: ED SEX: M
SPECIMEN ID: 11597

ACCOUNT #: 6134001
DATE/TIME COLL: 13-MAY-96 04:22 AM
DATE RECEIVED: 13-MAY-96
DATE/TIME REP: 16-MAY-96 08:30 AM

TEST NAME =====	RESULT =====	ABNORMAL =====	REFERENCE RANGE =====
--------------------	-----------------	-------------------	--------------------------

URINALYSIS/PARASITOLOGY/IMMUNOLOGY

URINE REFRIGERATED	NO		
URINE APPEARANCE	CLOUDY		CLEAR
URINE COLOR	YELLOW		YELLOW
URINE SPEC. GRAVITY	1.024		1.008-1.030
URINE LEUKO EST.	NEGATIVE		NEGATIVE
URINE NITRITE	NEGATIVE		NEGATIVE
URINE PH	5.0		5.0-8.0
URINE PROTEIN	NEGATIVE		NEGATIVE (MG/DL)
URINE GLUCOSE	NORMAL		NORMAL (MG/DL)
URINE KETONES	NEGATIVE		NEGATIVE
URINE UROBILINOGEN	NORMAL		NORMAL (MG/DL)
URINE BILIRUBIN	NEGATIVE		NEGATIVE
URINE OCCULT BLOOD	APPROXIMATELY 250		NEGATIVE (ERY/UL)
URINE RBCS	4+		NEGATIVE (/HPF)
URINE WBCS	NEGATIVE		NEGATIVE (/HPF)
URINE BACTERIA	2+		NEGATIVE (/HPF)
URINE CRYSTALS	NEGATIVE		NEGATIVE (/HPF)
URINE CASTS	NEGATIVE		NEGATIVE (/LPF)
URINE MUCUS	PRESENT		NONE SEEN (/LPH)
URINE SQUAMOUS CELL	FEW		NEGATIVE (/HPF)
URINE TRANSITIONALS	NEGATIVE		NEGATIVE (/HPF)
URINE OTHER CELLS	NEGATIVE		NEGATIVE (/HPF)

OWENS, WILLIAM

*** FANTOZZI, RONALD M/16-MAY-96 AT 08:30 *** (CONT) FINAL REPORT

500685.011.0443

NURSING CONTINUATION SHEET				DEPT. REPORT CONTINUED
PAGE 1 OF 1				
LAST NAME	FIRST	MIDDLE	DATE	
FANTOCZI	ROBERT		5/13/10	Owens
MEDICATION				
0500				Saline lock = #20x1 1/2" @ dental in (L) forearm. Labs drawn & sent. N/S flush instilled. Roster pain 10/10
0515				Dexameth 25 mg slow IV push followed by 5ml N/S flush/PR
0535				Phenyton 25 mg slow IV followed by 5ml N/S flush/PR
0550				Pain now 7/10
0515				Dexameth 25 mg IV followed by 5ml N/S flush = pain down to 5/10
0545				To XR via stretcher. Pain 7/10
0600	112/64	84	18	Returned from XR. Pain remains 7/10
0645				Assumed pt core
				Pt in x-ray for ENP =
				40 + discomfort
0650	114/60			35mg Dexameth IV = relief of discomfort for remainder of test
				Returned from x-ray - c/o + discomfort - pt sleeping on re-level.
				Eval. by Dr. Buge
0700				Toradol 30mg IV = relief of pain
0710				Dr. Mailhot informed
0745	102/60	72		In depts pt advised to prepare for home care
0800				Discharge
0800				Signature: [Signature]
0800				Signature: [Signature]

DOCTOR'S SIGNATURE

M.D.

MEDICAL RECORDS COPY

500685.011.0444

ST. MARY'S
REGIONAL MEDICAL CENTER
LEWISTON, MAINE

NURSING CONTINUATION
SHEET

DEPT. REPORT
CONTINUED

NO. 6134001

PAGE 2 OF 2

LAST NAME

FIRST

FANTOZZI, Ronald

1988

5/18/88

7/10/88

Notified pt. leaving hospital
of making phone call.
Pt. entered vehicle be-
hind wheel - drove
away

REPORT	SIGNATURE	REPORT	SIGNATURE
	RN/LPN		RN/LPN
	RN/LPN		RN/LPN

DOCTOR'S SIGNATURE

M.D.

MEDICAL RECORDS COPY

500685.011.0445

St. Mary's Medical Associates
 99 Campus Avenue, Lewiston, ME 04240
 (207) 777-8810

2334

St. Mary's Regional Medical Center
 Radiology Request Form

NAME: Fantozzi, Ronald SEX: M DOB: April 16, 1962
 SSN: 006-54-2724 PHONE (H): (207) 782-3873 (W): (207) 784-9186
 ADDRESS: 40 Poland Rd
 ADDRESS: Auburn, ME 04210

PHYSICIAN: Michael Boulanger, M.D.

Insurance1: HEALTHSOURCE ID#: 218103-01 Group#: M219
 Insurance2: ID#: Group#:

DIAGNOSIS:

ADD / (C) TRANS P.A.D., HX CROUDES

TYPE OF EXAM
 X-RAY:

IUP / ob-STRUCTURED LIVER

Diagnosis

HEP C CARC

CT SCAN:

NUCLEAR MEDICINE:

ULTRASOUND:

CARDIAC CATH:

OTHER:

MAMMOGRAPHY:

Reason for Mammography:

Previous Mammography: Yes NO Date: _____
 Where: _____ When: _____

Routine: _____ Palpable Mass: _____

Other: Discharge, Radiologist Recommendations, etc.:

Date of last menstrual cycle: _____

Hormone Therapy: _____

Scars/Paused Skin Lesions: _____

Family History: _____

Prev. Biop/ Aspiration _____

Pain: _____

Implants: _____

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Right Left
 SIGNED: _____

Michael Boulanger

St. Mary's Medical Associates
 48 Campus Avenue, Lewiston, ME 04240
 (207) 777-8810

NAME: Fantozzi, Ronald SEX: M DOB: April 16, 1962
 SSN: 006-54-2724 PHONE (H): (207) 782-3873 (W): (207) 734-9186
 ADDRESS: 40 Poland Rd
 ADDRESS: Auburn, ME 04210

PHYSICIAN: Michael Boulanger, M.D.

Insurance1: HEALTHSOURCE ID#: 218103-01 Group#: M219
 Insurance2: ID#: Group#:

DIAGNOSIS: ACUTE ABD. / (W) GASTR. PA.

BACTERIOLOGY

- ☐ Culture
- ☐ Source
- ☐ Blood
- ☐ Stool
- ☐ Throat
- ☐ Urine
- ☐ Other
- ☐ GC Screen
- ☐ Rapid Strep
- ☐ Strep Scrn Cult

CHEMISTRY

- ☒ Amylase
- ☐ Bilirubin, Micro
- ☐ Block 3 *
- ☐ BUN
- ☐ Calcium
- ☐ Coronary Rsk Prof
- ☐ Creatinine
- ☒ Electrolytes
- ☐ NA
- ☐ K
- ☐ FE/IBC
- ☐ Gluc Fasting *
- ☐ Gluc, Tol, Hr
- ☐ Gluc, 2hr. P.C.
- ☐ Gluc, 50 Gram
- ☐ HDL
- ☐ Lipids **
- ☐ Cholesterol
- ☐ Lipoprot **
- ☐ Triglyc **

THYROID

- ☐ T3 Uptake
- ☐ T4
- ☐ Total T3
- ☐ TSH
- ☐ Free T4
- ☐ Anti Micros Antibdy
- ☐ Anti Thyglobulin

COAGULATION

- ☐ Bleeding Time
- ☐ Coag Profile
- ☐ Prottime
- ☐ PTT

HEMATOLOGY

- ☒ CBC Auto Diff
- ☐ CBC Manual Diff
- ☐ Differential
- ☐ HCT
- ☐ HGB
- ☐ Platelet Count
- ☐ Retic Count
- ☐ Sed Rate
- ☐ WBC

OTHER

- ☐ Glycohemoglob
- ☐ PAP BY RIA
- ☐ PSA
- ☐ Ferritin
- ☐ B12 Folate
- ☐ Renal Panel
- ☐ Hep Panel

THERAPEUTIC DRUGS

- ☐ Digoxin
- ☐ Dilantin
- ☐ Lithium
- ☐ Phenobarb
- ☐ Theophylline

Urine/Feces/Preg

- ☐ Ova & Paras
- ☐ X Days
- ☐ Occult Blood
- ☐ Fec
- ☐ Rout Urinalys
- ☐ Rout Culture
- ☐ if indicated
- ☒ Comp Urinalys
- ☒ Comp Culture
- ☐ if indicated
- ☐ Pregnancy
- ☐ (Qual HCG) ser
- ☐ Pregnancy
- ☐ (Qual HCG) urn

☒ Chem 15 Profile ☒ Fasting 8 Hrs
☒ Fasting 12 Hrs

STAT

Michael J. Boulanger M.D.

4083090 C WALKED 00221342 FANTOZZI, RONALD M
 33 PIERCE ST 031Y /62 CT
 LEWISTON ME 04240

EME
 M M

3/30/94

JOHNSON, DAVID E. DEBRA
 BOULANGER, MICHAEL C

3/30/94 10:12 3/30/94 8:00
 400 86
 199999 COMMERCIAL 218103 01 HEALTHSOURCE FANTOZZI, RONALD M

Peri Boulanger

207-782-3873 207-782-3873 006542724

PRESENTING COMPLAINT: NECK PAIN

With Peri
 NKDA
 Neck stiff. Can't turn head
 to (L). No trauma

LMP	WEIGHT	SMOKER	OD	OS
TIME	TEMP	D	R	UP
1020	37.0	60	14	122/68

MEDICATIONS: *Tylenol Advil.*

TEST DONE:

- ☐ CBC
- ☐ LYES
- ☐ CRP
- ☐ ESR
- ☐ AMYLASE
- ☐ ETOM
- ☐ ECG/STEC
- ☐ TUBING
- ☐ CPA
- ☐ CUS
- ☐ SS
- ☐ OTHER TOP HOLD
- ☐ SAM 12
- ☒ EKG 7/2/94
- ☐ ASK
- ☐ HSA
- ☐ HBA

George Schlumberger

- 1025
 - *man started lifting*
 - *up at work m + off*
 - *not lifting x 1 1/2 hrs*
 - *sharp pain out to long*
 - *Fuelin 500*
 - *man started*
 - *no trauma*
 - *1 yr*
 - *chronic disease*

6B

no relief from meds. or
soft C-collar applied
some relief

Discharged with instructions

1046
1045

Dr. J. Radol
60y I.H.
Dr. J. Radol
Dr. J. Radol
Dr. J. Radol

George Schlumberger
 3/30/94 (152)

INITIALS: SIGNATURE: DATE: TIME:

DATE _____ TIME _____ INITIALS _____

CONSENT FOR TREATMENT

I hereby authorize the Physician or Physicians (and whomever he or they may designate as his or their assistants) in charge of my care at ST. MARY'S, to administer any emergency treatment and to administer such anesthetics and perform such operations and procedures as he or they may deem necessary or advisable in the diagnosis and treatment of my condition, recognize that the need for prompt medical attention precludes authorization of a more detailed or specific nature before proceeding, and to send the complete medical record to my Physician or the Physician I am referred to.

WITNESS D. Fitzherbert SIGNATURE Ronald F. [Signature] DATE AND TIME _____

Because the above patient is an unemancipated minor, _____ years of age, or, is unable to sign for the following reasons:

The above consent is given on the patient's behalf by:

WITNESS _____	CLOSEST RELATIVE OR LEGAL GUARDIAN _____
DATE _____ TIME _____	RELATIONSHIP _____

(NOTE, IF TELEPHONE CONSENT) _____

SAINT MARY'S REGIONAL MEDICAL CENTER

Lewiston, Maine

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

This is to certify that I, _____, an out-patient at St. Mary's Regional Medical Center, am leaving against the advice of the attending Physician and Medical Center authorities. I also acknowledge that I have been informed of the risk involved and hereby release the attending Physician and Medical Center from all responsibility for any ill effects which may result.

WITNESS _____ SIGNATURE OF PATIENT OR PARENT, IF MINOR _____

DATE _____ TIME _____

I, _____ give St. Mary's Regional Medical Center Emergency Department staff permission to photograph my injuries. I understand that these photographs will be kept at the Medical Center and be available if needed for legal purposes in the future.

Although duplicate copies will be taken, an original must always remain in the hands of the Medical Center.

WITNESS _____ SIGNATURE OF PATIENT OR PARENT, IF MINOR _____

DATE _____ TIME _____



EMERGENCY DEPARTMENT - 777-8120
AFTERCARE INSTRUCTIONS

Emergency Department Treatment is only the first step in your care. Follow up care may be important for your health and safety.

If you get worse, get new symptoms or don't get better, call your physician or return to the Emergency Department any time day or night.

X-rays and cardiograms (EKGs) are initially read by the Emergency Physician. They will also be reviewed by the hospital radiologist or cardiologist. You will be notified if any significant additional findings are noted.

You will be sent a separate bill for Emergency Physician care in the hospital Emergency Department. If you have any questions about the Emergency Physician's bill, please do not hesitate to contact us, toll free 1-207-539-8277.

PLEASE FOLLOW THE INSTRUCTIONS CHECKED BELOW:

- () Take your medication as ordered.
() Follow instruction sheet
() See Dr. _____ for follow up on ____ / ____ / ____ at ____
() Call Dr. _____ tomorrow, for appointment in ____ days
() May return to school on ____ / ____ / ____
() May return to Gym on ____ / ____ / ____
() Limitations _____
() May return to REGULAR/LIMITED DUTY work on ____ / ____ / ____
() Work as bandage/splint allows () No lifting
() One hand/one arm work () No lifting over ____ lbs.
() Dry work only () No squatting/kneeling
() Other () No bending or twisting
() Call WORK MED for appointment on ____ / ____ / ____ at
777-8816

OTHER

① collar for comfort / per verbal order
at night
② pain medicine / muscle relaxers
as needed
③ rest
④ No work for 2 weeks
⑤ Follow up with Dr. [illegible]
⑥ Return to work as tolerated

I HAVE READ AND UNDERSTAND THE ABOVE INSTRUCTIONS:

3/24/01 [Signature]
DATE: 3/24/01 BY: [Signature]
ACCOUNT NUMBER: 4289000

PANTOZI, Ronald M. Johnson BMRMC 03/30/94
Medical Record #: 221342 Account #: 4089093
DOB: [REDACTED]/1962 Arrived: 1012 Examined: 1025

PRESENTING PROBLEM: Neck pain.

HISTORY OF PRESENT ILLNESS: The patient is a 31-year-old male who arrived ambulatory for evaluation of left-sided neck pain. He said that he had some mild discomfort yesterday. When he woke up this morning it was more intense. He has noted he has a difficult time turning his head to the left. He also has discomfort with flexion, more than extension. He denies problems with strength and sensation. He has no bowel or bladder control problems.

He denies any trauma.

He apparently has had some mild neck discomfort on-and-off for about one year, but nothing as intense as this. He does some regular neck stretching exercises at work. He started weight lifting about an hour and a half ago lifting about 45 minutes mostly everyday.

He has no fever, chills or sweats. He has no cough or shortness of breath. He denies any systemic symptoms.

PAST MEDICAL HISTORY: Crohn's disease. He has had surgery for that as well as a cholecystectomy.

SOCIAL HISTORY: He does not smoke cigarettes. He works in a shoe shoe.

ALLERGIES: None.

MEDICATIONS: None.

IMMUNIZATION STATUS: Tetanus 1992.

PERSONAL PHYSICIAN: Dr. Boulanger.

PHYSICAL EXAMINATION: At 1020 hours: Vital Signs: Temperature 37.0, pulse 68, respiratory rate 14, blood pressure 122/68. General appearance: The patient is awake, alert and he does appear uncomfortable with his head cocked sideways.

NECK: Not tender. He does have some tenderness, however, just to the anterior proximal portion of the trapezius. He has no tenderness, although he points to the area of the proximal anterior trapezius going up the lateral aspect of the left side of his neck as being the most sore area. The patient has marked decreased range of motion. He is barely able to get any movement rotating to the left. He has good upper and lower limb power, both proximally and distally. He is able to discriminate sharp from dull and he has no sharp level deficits from his fingertips to his neck. Deep tendon reflexes are +3 and symmetrical.

NECK: Supple with no enlarged nodes.

THROAT: Not red and there is no swelling.

TEST INTERPRETATIONS:

X-RAYS: Read by radiologist.

CERVICAL SPINE: Negative.

PANTOZI, Ronald M. Johnson SMRMC 03/30/94
Medical Record #: 221342 Account #: 4089093
DOB: [REDACTED]/1962 Arrived: 1012 Examined: 1025

ED COURSE/PROCEDURES: The patient was given 60 mg of Toradol IM and 10 mg of Flexeril by mouth at 1045 hours. By 1145 hours there was some mild change, but nothing significant.

ASSESSMENT:

1. Neck strain - possible acute disk; however, without neurologic symptoms.

DECISION MAKING/TREATMENT/COUNSELING/CARE COORDINATION:

1. Soft cervical collar for comfort.
2. Cervical pillow, which he may use at night.
3. Acetaminophen #3 one to two q.4-6h. (25, no refills, no driving).
4. Flexeril 10 mg (1 q.8h., 21, no refills).
5. Rest.
6. No work before the 5th of April.
7. Follow-up with Dr. Parisien.
8. Return if worse or new problem i.e. weakness, numbness or problems with bowel or bladder control.
9. I reviewed the instructions with him and he understood them.

CONDITION AT DISCHARGE: Good, ambulatory.

Time Out: 1150


David E. Johnson, M.D.

DOD:03/30/94 DEJ/tai

DOT:03/30/94

cc: Dr. Boulanger ✓

Dr. Parisien ✓

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ST. MARY'S REGIONAL MEDICAL CENTER
LEWISTON, MAINE 04240

RADIOLOGY REPORT

NAME FANTOZZI, RONALD M
STREET 93 PIERCE ST
CITY LEWISTON
STATE ME ZIP CODE 04240 FLOOR

DATE OF BIRTH [REDACTED]/62 MED REC # 22-13-42
X-RAY # 08-99-89 HOSP # 4089093
SERVICE DATE 03/30/94 PHY(S) JOHNSON, DAVID E.
DATE TYPED 03/30/94 PHY(S) BOULANGER
TIME COMPLETED 13:31:18

Indication for Study: Left cervical paraspinal pain, R/O pathology

FINDINGS:

CERVICAL VERTEBRAL COLUMN: The vertebral bodies are intact. The intervertebral joint spaces are normal. There is no encroachment or enlargement of the neural foramina.

CONCLUSION: Nothing abnormal is seen in the cervical